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EDITOR'S CHOICE

Facelift

Cosmetic surgery has become big business to deal with our wrinkles when they displace those previously pleasing rounded outlines, and the slow deterioration that often occurs in the person and surrounds of elderly folk who are no longer able to cope sometimes necessitates external intervention to get things back on track.

These may not be the best analogies to illustrate the periodic renewal process undertaken by even the most successful medical journals. The previous *SAMJ* cover image and inside layout served it well, but this issue marks the birth of a new presentation. Readers will note the crisp cover and improved layout of the contents, which should be easier to follow. For an excellent inside job we congratulate our staff members, especially Siobhan Caulfield, who is responsible for DTP and layout, and Anne Collins, production manager.

Rape and HIV — ethics and the law converge

Politics, ethics and the law may have divergent responses to health care issues. It is only recently that the National Department of Health has expressed support for the provision of antiretroviral therapy for rape survivors. They reached this conclusion after being at the receiving end of the courts, but the delay in getting there means that planning and implementation lag far behind the needs of society. In this setting there have been mixed messages from health care authorities, and at times medical practitioners and others have suffered under the heavy hand of management. Such action against the doctors may have occurred despite their acting according to ethical principles, but what are their rights under the law?

McQuoid-Mason *et al.* (p. 41) explore the right to emergency medical treatment of rape survivors in order to prevent HIV infection. They consider the duties of police officers, medical practitioners, state hospitals and private hospitals, and also consider the role of non-governmental organisations in such cases.

Rape, which is legally defined as 'intentional and unlawful sexual intercourse with a woman by a man without her permission', constitutes a 'sudden catastrophe' which in the light of the HIV/AIDS epidemic in South Africa calls for immediate medical treatment to prevent the survivor from contracting HIV. The authors consider that each of the above groups who see rape survivors have clear responsibilities under the law. If they fail to meet their responsibilities and the rape survivor contracts HIV as a result, she will be able to sue them for damages for pain and suffering, loss of life expectancy, loss of income and any medical expenses incurred as a result of such infection.

Doctors have no general ethical or legal duty to treat a stranger as a patient, except in emergencies. Where hospital authorities prevent doctors from providing prophylactic treatment such as antiretroviral drugs to prevent HIV infection, the doctor is faced with dual loyalties. In emergency cases when doctors are faced with a conflict between demands from their employers and the interests of their patients, the latter should prevail. Any punitive action against the doctor seeking to act ethically and constitutionally would be unlawful!

Rational rationing

Doctors in the public health care system have a healthy scepticism about the term rationalisation, which in their experience is usually a euphemism for rationing or even abolishing services. While doctors are frustrated when they cannot deliver services to needy patients, those who are responsible for the policies and distribute the goods are frustrated by being unable to deliver on the competing calls for cash and resources. Kenyon and colleagues (p. 56), in their seminal article, note that antiretroviral therapy (ART) at current costs is unaffordable to the majority of the world's population. This represents the first time a highly efficacious treatment for a mass condition, and one for which there is no substitute, is unaffordable to the majority afflicted by the condition. They propose an ART programme which they convincingly argue is not only affordable but also vital for basic human rights reasons, to enhance prevention efforts and to keep the fabric of society together.

This article deserves serious consideration by all who are involved in the policy and practice of health care.

Male hegemony versus the feminisation of medicine

A silent revolution has been stalking the corridors of medicine for several decades. This revolution relates not to the way medicine is practised or taught, but to the massive shift in gender proportions.

Kane-Berman and Hickman (p. 69) report on women doctors in medical professional organisations in South Africa. Their main finding is that the composition of the medical professional organisations in this country is predominantly and disproportionately male, as are their governing bodies. Since women medical students outnumber males in several medical schools in South Africa, and by 2020 50% of the medical workforce will probably be female, this has important implications.

What has even greater implications for this country is that no official regulatory or governing body has seriously investigated the potential impact of this gender shift in medicine in order to develop plans to cope with the potential effects thereof.

JPvN